



INDIGENOUS LIAISON REFERRAL FORM

Phone: (Flin Flon) 204-687-9338 ext. 30618
(The Pas) 204-623-9248 ext. 30199
(Thompson) 204-677-1776 ext. 8776

Client Label

Date of Referral: _____ Inpatient Outpatient Client is Aware of Referral
(dd/mmm/yyyy)

Referred By (Include Department): _____

Date Notified: _____ Name of Notifier: _____
(dd/mmm/yyyy)

Home Community: _____ Treaty Number: _____
Band Number: _____

Reason for Referral (Please Check all that Apply):

- Advocacy Assessment/Support Coordination with FNIHB
- Discharge Planning Interpreter Spiritual Care

Additional Information: _____

Name of Referrer (Please Print Clearly): _____

Signature of Referrer: _____

- Referral Received Client Seen Please See Integrated Progress Note

Additional Comments: _____

Indigenous Liaison (Signature): _____

Date: _____
(dd/mmm/yyyy)